Better Value, Better Outcomes: The Potential of the Patient-Centered Medical Home

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Employee Benefits Planning Association

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Today's Agenda

- About the Puget Sound Health Alliance
- The Need for Better Value, Better Outcomes
- What is a 'patient-centered medical home' and why employers care?
- What needs to change to make it work?

Quick Break

- A Payer Perspective on National Developments
- What's going on here in Washington?
- What can employers do?

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Alliance Role: Show How Care Varies and Promote Better Value

- Purchasers, Providers, Health Plans & Patients – 150+ member organizations
- 2 million lives, 5 counties
- Funded by participant fees and grants
- Participant in the Robert Wood Johnson Foundation Aligning Forces for Quality Initiative
- DHHS Chartered Value Exchange

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A Sampling of Who We Are . . . .

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Alliance - Key Strategies

- Performance Measurement/ Public Reporting
- Performance Improvement
- Consumer Engagement
- Payment Reform

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The Need for Better Value, Better Outcomes

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The Current State of Health Care

- We're spending more…
  - The U.S. pays more for health care than any industrialized nation
- But more money doesn't mean better care
  - Our outcomes are worse than nations that spend less
- Cost and quality vary widely, nationally and locally
  - Reducing unwarranted variation could potentially improve quality and curb spending by 30%

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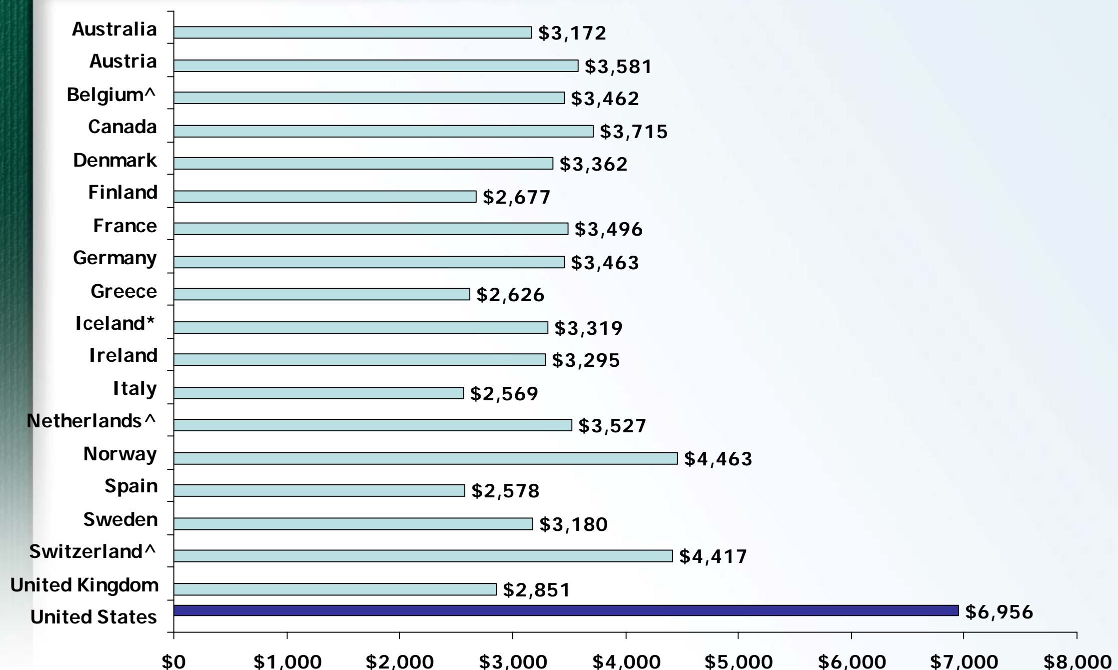
Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2007



Source: Organisation for Economic Co-operation and Development. OECD Health Data 2009, Copyright OECD 2009, http://www.oecd.org/health/healthdata

National Health Expenditures Per Capita, 1990-2019

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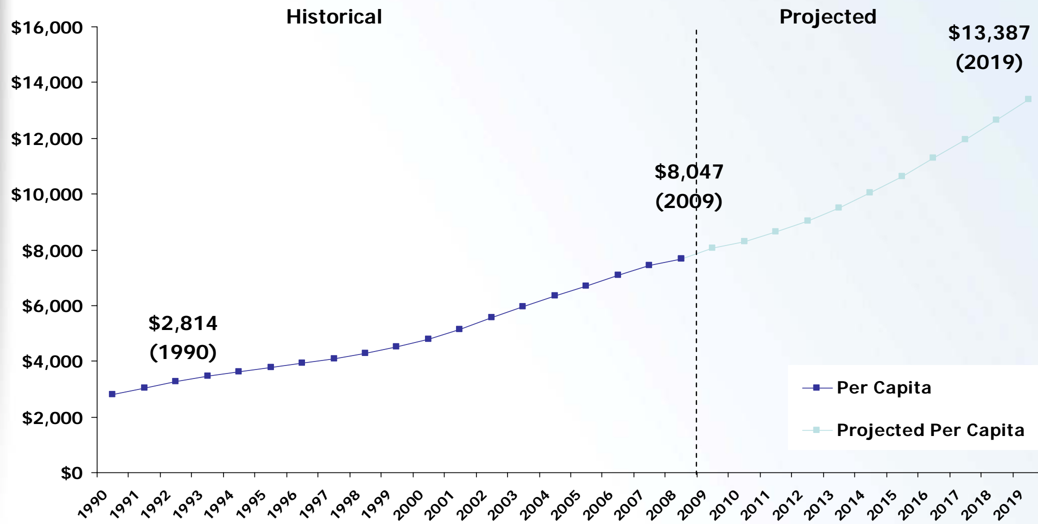

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (Historical data from NHE summary including share of GDP, CY 1960-2008, file nhegdp08.zip; Projected data from NHE Projections 2009-2019, Forecast summary and selected tables, file proj2009.pdf).

Wide Swings in Cost and Care

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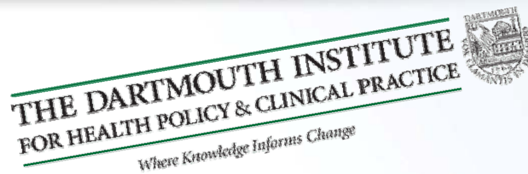

- The Dartmouth Atlas uses Medicare claims data to track how cost and quality vary across the U.S
- The Results:
  - There is huge, unwarranted variation in Medicare spending by region (population-adjusted)
  - Patients in high-cost areas are not sicker nor do they have better health outcomes
  - More health care spending does not result in living better or longer - In fact, the opposite may be true

A Tale of Two States:

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Per Beneficiary	New Jersey	Utah
Total Medicare Reimbursements (Last 2 Years)	$59,379	$40,310
Inpatient Days (Last 2 Years)	27.1	11.6
Physician Visits (Last 2 Years)	89.8	36.1
➢10 MDs Seen (Last 6 Months)	46.8%	14.7%

Source: Dartmouth Atlas (2001 – 2005)

What About Washington State?

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Per Beneficiary	New Jersey	Utah	Washington
Total Medicare Reimbursements (Last 2 Years)	$59,379	$40,310	$40,649
Inpatient Days (Last 2 Years)	27.1	11.6	12.9
Physician Visits (Last 2 Years)	89.8	36.1	42.6
➢10 MDs Seen (Last 6 Months)	46.8%	14.7%	20.9%

Source: Dartmouth Atlas (2001 – 2005)

What About Within Washington State?

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Per Beneficiary	Swedish (Seattle)	St. Peters (Olympia)	Sacred Heart (Spokane)
Total Medicare Reimbursements (Last 2 Years)	$57,105	$43,401	$47,915
Inpatient Days (Last 2 Years)	22.0	13.5	18.3
Physician Visits (Last 2 Years)	58.5	43.0	51.4
➢10 MDs Seen (Last 6 Months)	38.7%	22.9%	30.0%

Source: Dartmouth Atlas (2001 – 2005)

Here in Puget Sound:

Wide variation exists across measures and populations

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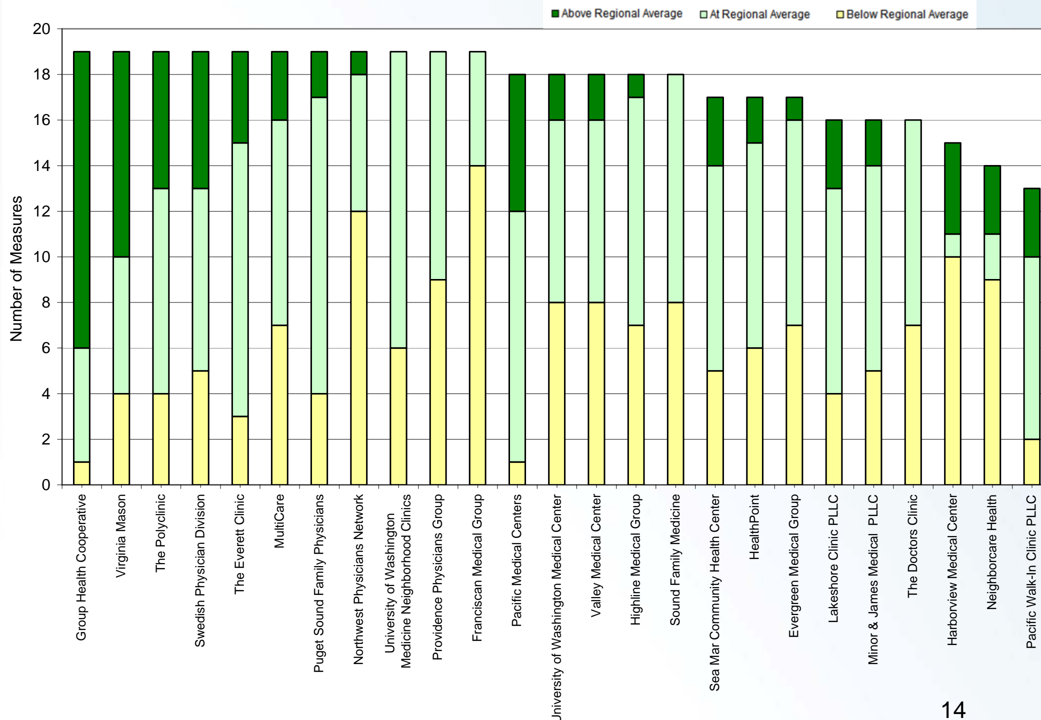

Here in Puget Sound:
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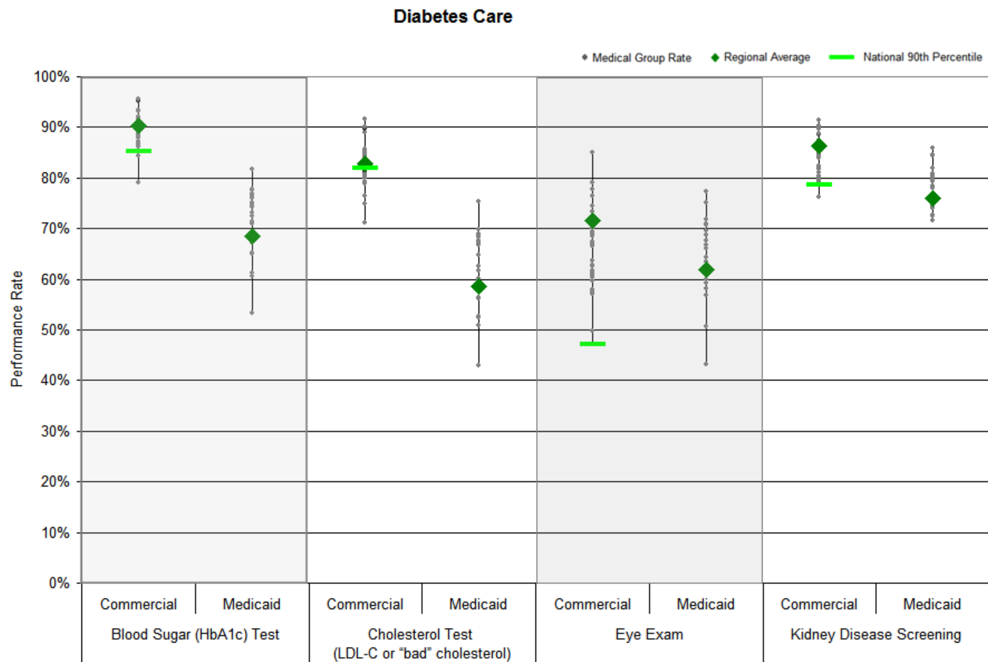

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Variation in Cost, Quality

Relevancy for Employers

Cumulative Changes in Health Insurance Premiums, Inflation, and Workers' Earnings, 1999-2009

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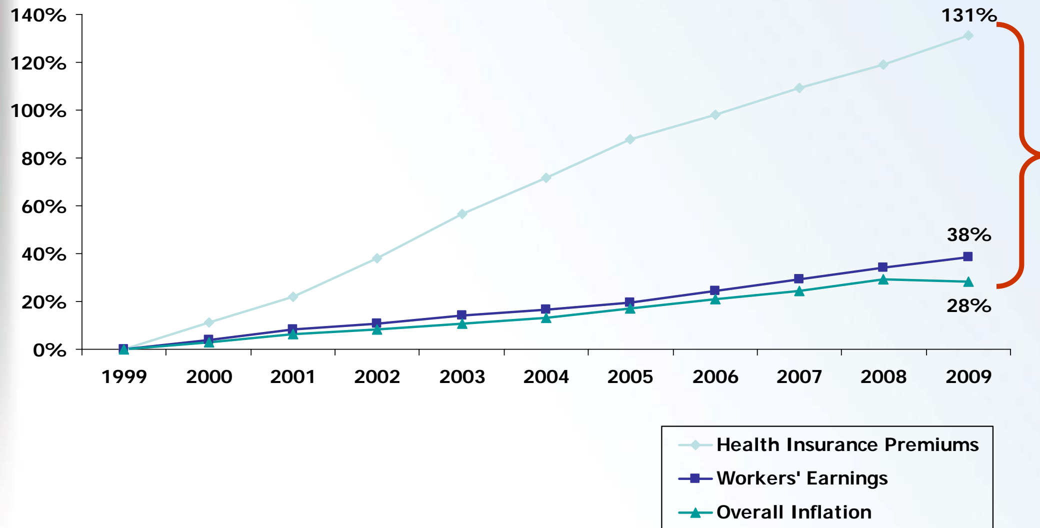

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2009; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2009 (April to April).

The Impact of Chronic Disease

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- Americans are living longer and working longer
- The number of Americans with chronic conditions is increasing dramatically
- About one third of all working age adults have two or more chronic conditions
- One fifth of individuals with chronic illness also have significant activity limitations
  - Impact on productivity, absenteeism, disability
- People with chronic conditions account for 84% of all health care spending
- 78% of spending for the privately insured is for individuals with chronic conditions

Source: Medical Expenditure Panel Survey, 2006

Putting Off Care Because of Cost

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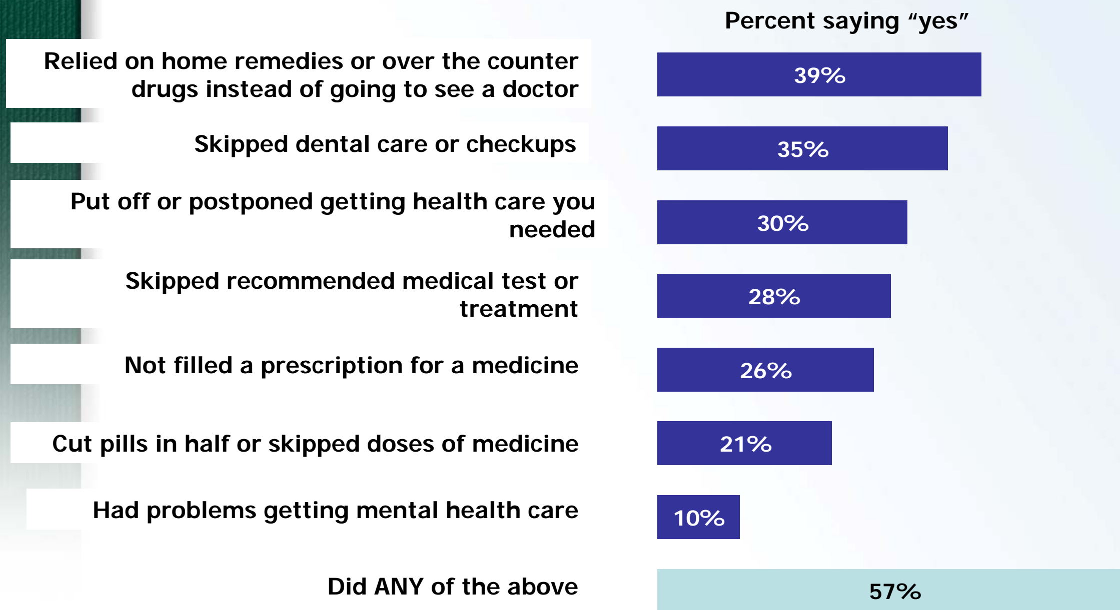
In the past 12 months, have you or another family member living in your household… because of the cost, or not?



Source: Kaiser Family Foundation *Health Tracking Poll* (conducted March 10-15, 2010)

Distribution of National Health Expenditures, by Type of Service, 2008

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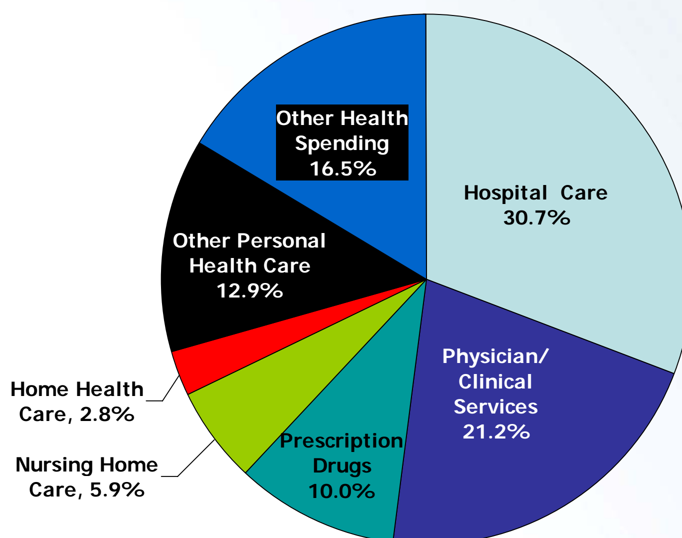

Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2008; file nhe2008.zip).

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Estimated Preventable Hospitalization Costs (2006) for the Puget Sound Area

A 10% reduction in avoidable hospitalizations could result in an estimated $23 million in four counties alone:

- Complications from Diabetes $2.9 million
- Congestive Heart Failure $5.3 million
- COPD $1.8 million
- Bacterial Pneumonia $4.8 million
- Urinary Tract Infection $1.7 million
- Low Birth Weight $6.8 million

Source: Agency for Healthcare Quality Research (AHRQ), Healthcare Cost and Utilization Project (HCUP)

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Primary Care: The Best Value in Medicine"

There is good evidence that increased patient management and care coordination *in the primary care setting* effectively contributes to avoidance of costly, unnecessary care and enhanced patient well-being.

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Primary Care - An Endangered Breed?

- In the past 10 years, approximately 90% of medical school graduates have opted to enter higher-paid sub-specialties such as orthopedic surgery, radiology and dermatology. About 10% have chosen primary care (AAFP).
- Currently, about 70% of all doctors are specialists and 30% are in primary care.
- All at a time when the population is aging and the incidence of chronic disease is on the rise.
- Current fee-for-service payment system undervalues primary care and does not adequately reimburse providers for non-visit based services or reward quality and value.

So, how does all of this all relate?

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- Duplication of or unnecessary medical evaluation and diagnostic testing and overuse of the acute care sector are significant contributors to overall cost.
- Hospitalization and use of the emergency room to address exacerbations of chronic disease can be avoided some or much of the time.
- Primary care is a discipline at risk and is shrinking in the face of shrinking margins, growing demand and increasing clinical complexity (patients with multiple co-morbidities).
- The erosion of primary care will undermine efforts to deliver higher value health care. If primary care deteriorates further (including access), cost and quality will worsen, not remain the same.
- We need to 're-build' a primary care system that works.
- Purchasers have a role to play.

So, what is the 'patient-centered medical home?'

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aka "Advanced Primary Care"

- Each patient has an ongoing relationship with a personal provider (MD, NP) trained to provide first contact, continuous and comprehensive care
- Team of individuals at the practice level who collectively take responsibility for the ongoing care of patients
- 'Whole person' orientation - care for all stages of life; acute care; chronic care; preventive services; and end of life care
- Evidence-based medicine and clinical decision-support tools guide decision making
- Care is coordinated across all elements of the complex health care system

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What Needs to Happen to Make it Work?

- Payment Reform
- Provider and Health Care Team Education
- Enhanced access to primary care
- Adoption of health information technology – practice support tools, exchange of information
- Base care decisions on the evidence (when available)
- Shared decision-making, patient-centered care
- Shift in culture, quality improvement, measurement
- Strong coordination with specialists, hospitals and other
- Value-based benefit design - consumer engagement, primary care selection

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What is the opportunity?

- Less avoidable use of the emergency room, hospitalizations, and readmissions
- Better coordination of specialists
- Less duplication of diagnostic testing
- Less non evidence-based interventions
- Patient engagement
- Better patient experience and health outcomes
- Better productivity, less absenteeism

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Let’s take a break!

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Others are leading the way with multi-payer payment pilot efforts

Colorado
Maine
New Hampshire
New Jersey
New York
Pennsylvania
Rhode Island
Vermont

CIGNA is involved in many of these pilots.

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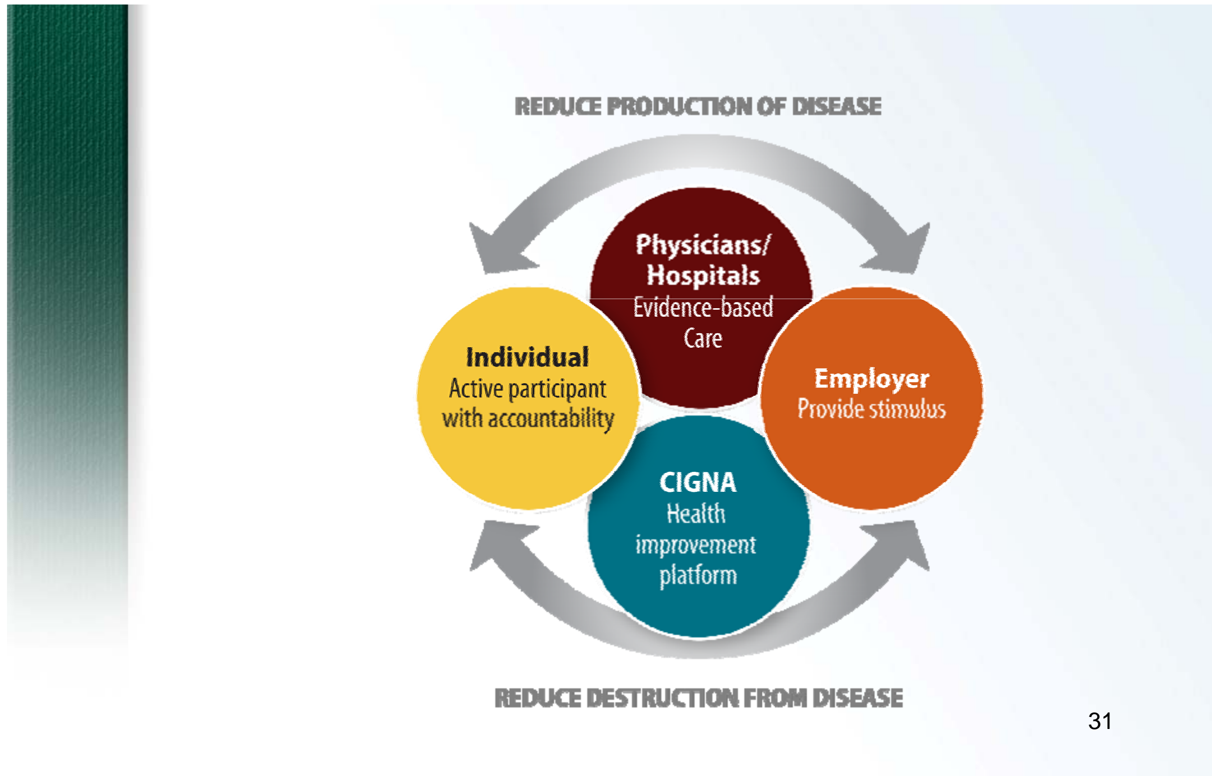
A Payer's Perspective

Mary Kay O'Neill, MD, MBA
Chief Medical Officer
CIGNA, Pacific Northwest

Align Stakeholder Roles and Strategies



Accelerating Transformation

- Comprehensive
  - Focus on population based care-prevention through acute management
- Choice
  - Must work in open fee-for-service environment
- Collaborative
  - Leverage Plan health advocacy and informatics
- Accountable
  - Reward not for volume, but for comprehensive value-improvement in BOTH total Medical cost and quality
- Payment Reform
  - Administer rewards not through fee schedule adjustment but through CPT G code for case management

Key Focus Areas

Access	Value Referrals
Informatics Enabled Embedded Case Management	Value Pharmacy
Evidence Based Care Acute Chronic Preventive	
Engaging Patients Informing Empowering	
Consistent with the principles of - Patient Centered Medical Home - National Priorities Partnership - Institute of Medicine	

Aligned Principles and Priorities

Institute of Medicine

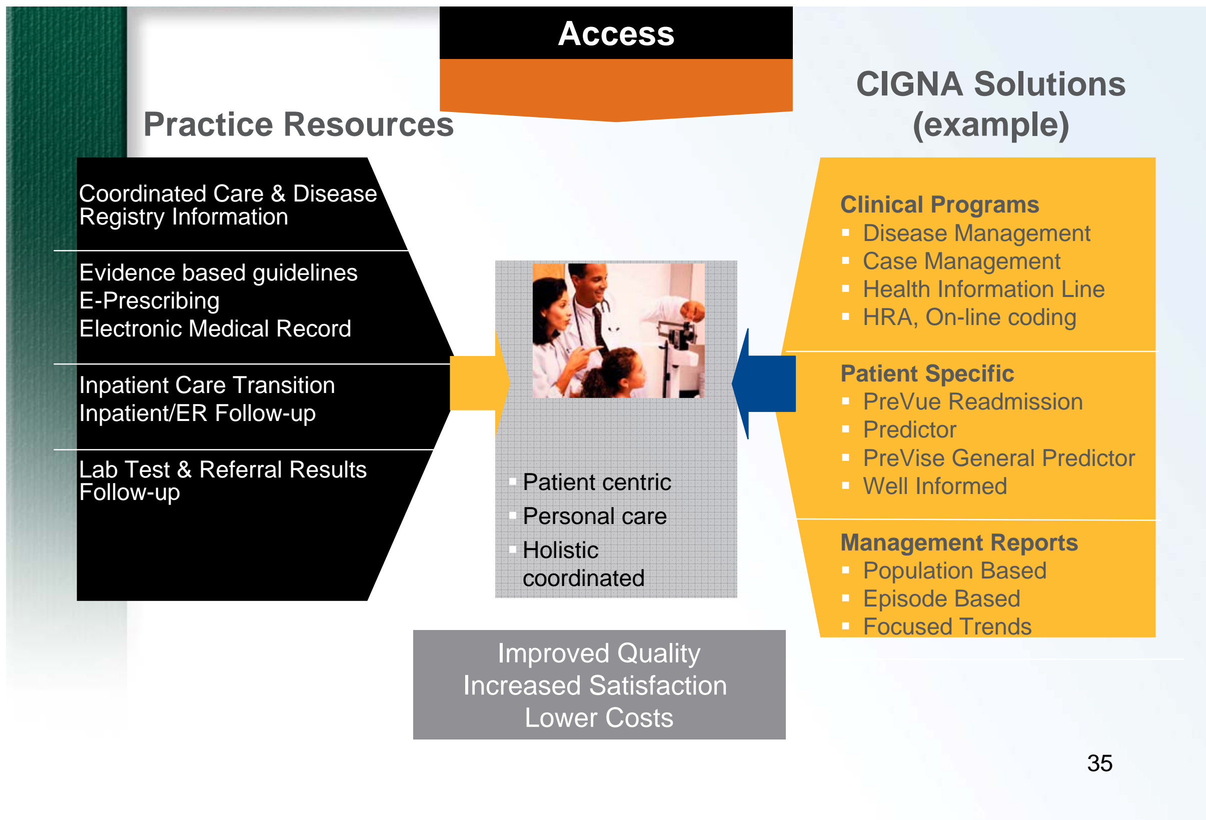
- Safe
- Timely
- Efficient
- Effective
- Equitable
- Patient Centric

Patient Centered Medical Home

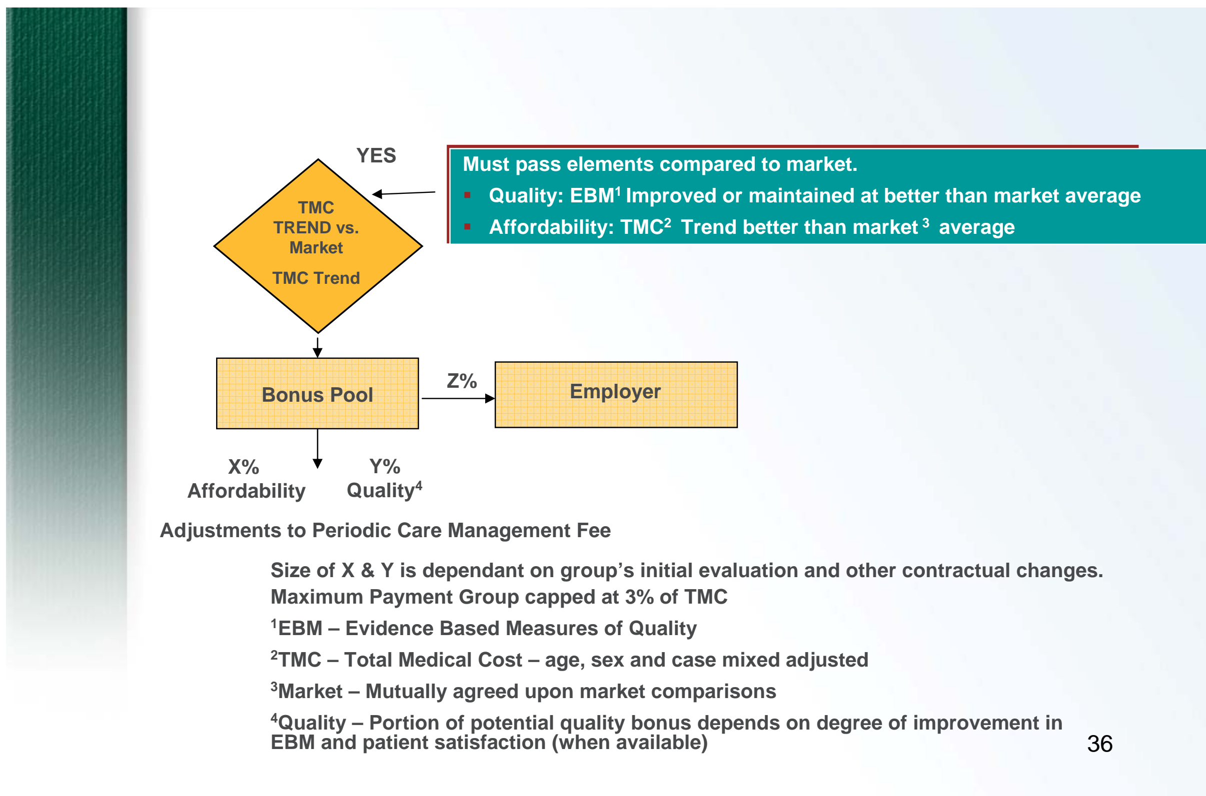
- Personal Physician
- Physician directed practice
- Whole-Person orientation
- Coordinated care
- Quality and safety
- Enhanced access
- Payment for value

National Priorities Partnership

- Engage patients
  - Choice on preference sensitive surgery
- Improve preventative health
  - Reduce preventative services gap
- Guarantee appropriate End of Life care
  - Increase comfort, reduce inappropriate chemotherapy
- Insure safety and reliability
  - "Never" and "Preventable" events
- Reduce unnecessary care while ensuring appropriate care
  - Inappropriate medications, Unnecessary tests, consultations and procedures, Preventable ER visits
- Ensure well coordinated care
  - Potentially preventable readmissions



Comprehensive Medical Home Reward Structure



Consumer Engagement

Phase I:

- Optimize communication plan
- Incorporate Experience of Care Surveys into Outcomes Measures
- Consumer advisory group

Phase II

- HRA improvement
- "Patient Activation Measure", health status, absenteeism, presenteeism

What's Happening Closer to Home?

- Boeing Pilot – "Ambulatory ICU"
- Group Health
- Swedish Ballard Family Practice
- Multi-Payer Medical Home Reimbursement Pilot

Early Local Results

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Boeing Pilot – "Ambulatory ICU"

- Pilot launched Q1 2007
  2 ½ -year pilot
- Focused on ~500 predicted high cost Boeing employees and their dependents; three clinic locations (VM, The Everett Clinic, Valley)
- 20% savings compared with its control group after factoring in the additional money paid to doctors
- Average number of workdays missed by patients in the last six months of the program dropped by 56%
- High patient satisfaction

Group Health – Factoria Medical Home Pilot

- 29% reduction in ER visits; 11% reduction in ambulatory sensitive admissions
- At 24 months, statistically significant reduction in total costs
- High patient and provider satisfaction
- Implementing across all area medical centers

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Washington State Multi-Payer Pilot

- Started with the Primary Care Coalition
- Legislation in 2009, Governor's Support
- Alliance purchasers met March 2009 and agreed to 'champion' this work
- WA State Health Care Authority in the lead
- Formal invitation to plans, providers to collaborate
- Co-convene (Washington State, Alliance)
- 'Participant Group' Formed June 2009
- October 2009 Payment Reform Summit to engage stakeholders
- Six Workgroups To Date
- One of Three RWJF Payment Reform Grant Sites Nationally

Legislation - SSB 5891

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- Declares collaboration among third party payers (public, private) to identify new reimbursement methods to align incentives in support of primary care medical homes in best interest of the public
- Activities undertaken as part of state-sponsored pilots exempt from state antitrust laws and provides immunity from federal antitrust laws through the state action doctrine
- Washington State in lead (HCA, DSHA)
- Design, oversee implementation and evaluation

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Why Multi-Payer?

- Physicians will respond to incentives if the incentives are meaningful and proportional to the effort required to get the incentive
- Need multiple payers to impact significant portion (>50%) of provider's practice; very difficult and likely ineffective (unsustainable) for them to 'transform' for a smaller carve out of their overall practice
- Inadequate number of payers (e.g., single payer) results in one plan subsidizing the share of other plans to drive improvement (large national plans are learning this)

Washington State Multi-Payer Pilot

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- Link payment to specific, targeted outcomes
- Not (yet) pushing for full medical home implementation
- The pilot is *an early step* in a much larger transition that needs to occur in which policy and culture support a strong tie between reimbursement and value.
- Our objectives are to: (1) link payment to outcomes in some fashion, (2) invest in change, AND (3) begin to stabilize and strengthen the primary care sector of the delivery system.

Testing Payment Models
Finding the "Sweet Spot" for Payers, Providers

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Plan 1

- Fee for service (FFS) + care management fee (CMF) + shared savings
  - Additional revenue to practices
  - Intended for small to medium sized practices needing capitalization
  - Minimum practice size
  - Will include all payers
  - Limited in scope/size due to initial investment by payers
  - Investments tied to outcomes in ER and hospital use
  - Threshold measures in quality, patient experience
  - If outcomes not met, reduction of up to 50% of additional investment

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Plan 2

- FFS reduction + CMF + shared savings
  - Revenue neutral
  - Intended for clinics that have already made investments and are well positioned to achieve targets
  - Practices may recoup some costs from savings before sharing savings
  - May include all payers
  - Targeted outcomes: ER and hospital use Threshold measures in quality, patient experience
  - Savings shared through increased PMPM

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Participating Health Plans

- Premera Blue Cross
- Regence Blue Shield
- Group Health
- Aetna
- CIGNA
- United Healthcare
- Molina
- Community Health Plan of WA

Practice Transformation "Core Competencies"

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- Advanced access
- Extended hours
- Pro-active chronic disease management (registries, outreach, after-visit summaries, self-management)
- *System* for care coordination
- *System* for communication with hospital team
- Strong service culture
- Team environment

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Status

- Call for interested practices - August
- Applied to be CMS Demonstration site - August
- Wrapping up payment model details - now
- Practice selection - end of September
- Baseline data, practice specific targets, plan-practice contracting - November, December
- Launch 1st Quarter 2011

Challenges

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- This type of collaboration is new territory
- Risks/Investments during tough economy
- Health Insurance Reform
- Complex undertaking – lots of moving parts
  - Keeping *everyone* on the path
- Resources, especially for practice support and data aggregation
- Timely feedback/data to practices
- Plans - administrative implementation
- Consumer engagement
- Aligned benefit design
- Beyond the practice setting – engaging hospitals and other community resources

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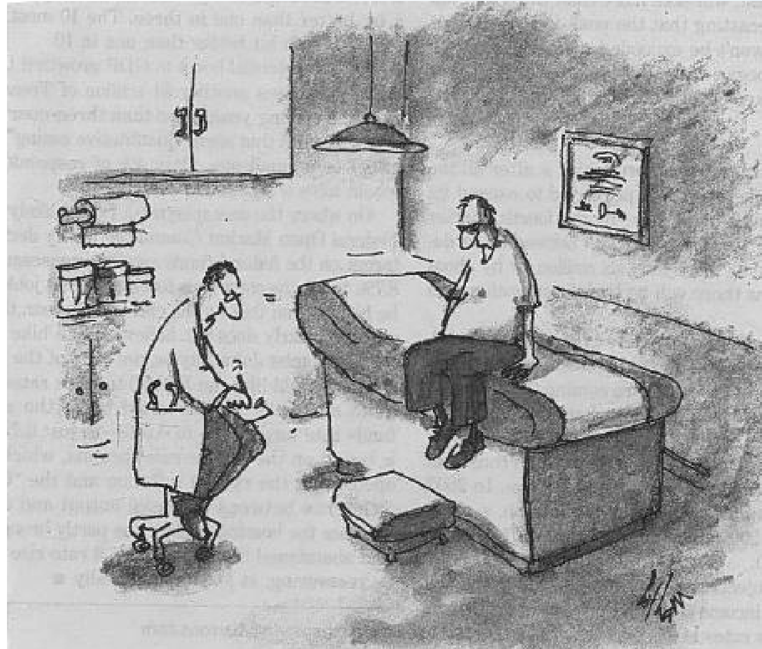
Why Should Purchasers Support the 'Patient-centered Medical Home?'

1. The magnitude of the problem
2. You have a lot at stake
3. You can be effective agents of change, particularly when you work together
4. You are a consumer
5. Evidence on effectiveness of primary care
6. Decline of primary care
7. Status quo is <u>not</u> the answer

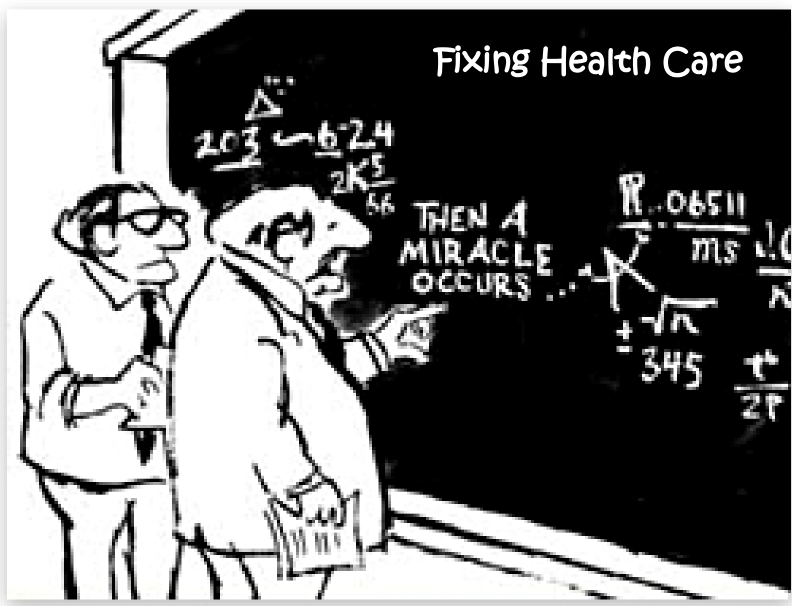
Consumer Engagement is Key



And just what qualifications do you have to choose your own doctor or make decisions about your health care?

What can you do?

- Work with other purchasers to align efforts, have common agenda – build coalition support
- Support local, regional pilots
  Encourage health plans to participate
- Incorporate medical home elements into insurer procurement and performance assessment activity
- Align benefit design with evidence, value-based activity – incentivize relationship with primary care
- Engage consumers


Fixing Health Care
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